88- 1808

SUPREME COURT, U.S.
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No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

RICHARD D. BUSHMAN, D.P.M.,
ROBERT L. BUSHMAN, D.P.M.,
Petitioners,

VS.

UNITED STATES OF AMERICA,
Respondent.

On Petition for a Writ of Certiorari to the
United States Court of Appeals for the Eighth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

A. With regard to the jurisdiction of the federal courts:

1. Did the federal district court lack subject matter jurisdiction over the Bushman's constitutional claim of denial of due process under the Fifth Amendment?

2. Did the federal district court lack federal question jurisdiction under 28 U.S.C. § 1331 over the appellant's medicare claim because the court is precluded from hearing such claims by 42 U.S.C. § 1395ii, as well as by 42 U.S.C. § 1395ff(b)(1)(c)?

B. With regard to the constitutional issue of deprivation of due process:

1. Assuming the federal district court had the requisite jurisdiction, did it err in failing to find that the Bushmans were deprived of their right to due process under the Fifth Amendment to the U.S. Constitution because, as the appellants aver, their claim arose out of the method employed by the U.S. Government to deprive them of their right to due process rather than a disupte over mere amount determination?

2. Were the Bushmans' claims for benefit payments constitutional claims which were related to procedures which were collateral to, and not inextricably intertwined with, claims for entitlement?

LIST OF PARTIES

The parties to the proceedings below were petitioners Richard D. Bushman and Robert L. Bushman and respondent the United States of America.

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OPINIONS BELOW

The opinion of the court of appeals is reported at 862 F.2d 1327. This opinion is reprinted as Appendix A in the appendix to this petition, and the court of appeals' opinion denying appellants petition for rehearing is reprinted as Appendix B in the appendix. The opinion of the district court is reported at 661 F.Supp. 266 and is reprinted as Appendix C in the appendix.

JURISDICTION

The Bushmans petitioned for a writ of certiorari to review the judgment of the United States Court of Appeals for the Eighth

Circuit in this case. The jurisdiction of the district court was invoked pursuant to 28 U.S.C. Sec. 1331.

The opinion of the district court was entered on March 5, 1987.

The opinion of the court of appeals was entered on December 9, 1988. Its opinion denying the petition for rehearing was entered on January 18, 1989. The jurisdiction of this Court is invoked under 28 U.S.C. Sec. 1254(1).

CONSTITUTIONAL PROVISION INVOLVED

The relevant Constitutional provision involved in this case is the Fifth Amendment which, in its relevant part, provides:

> No person shall . . ., nor be deprived of life, liberty, or property, without due process of law; . . . .

STATEMENT OF THE CASE

Richard and Robert Bushman, identical twin brothers, are podiatrists who treated aged occupants of nursing homes pursuant to Part B of Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395 *et seq* (Medicare Act). Claims for benefits were assigned by these patients to the appellants pursuant to 42 U.S.C. Sec. 1395(u)(b)(3)(B)(ii). Then the Bushmans would file forms, requesting payment, with General American Life Insurance Company (hereinafter termed GALIC), which was authorized by the Secretary of Health and Human Services to act as the carrier which would make payments to the doctors for the medical services they provided.

In December, 1981, an employee of GALIC's Medicare Program Control asserted that the Bushmans, during the period between October, 1979 and October, 1981, had been reimbursed (by GALIC) for treatment that was medically unnecessary. This employee demanded that the Bushmans received overpayments on their claims for, respectively, $11,784.00 from Richard and

$9,139.20 from Robert, plus interest. The Bushmans then requested a fair hearing which was held pursuant to 42 U.S.C. Sec. 1395(b)(3)(c) and 42 C.F.R. § 405.801 *et seq.*, on March 19, 1982 by a hearing officer in the employ of GALIC by the name of Linda Benso. The podiatrists submitted 251 claims. Benso paid on 42 of them and rejected the remaining 209 claims. The Government of the United States then demanded payment from Richard in the amount of $9,047.04 and from Robert in the amount of $7,484.00. The Bushmans hotly denied that they owed the United States anything and refused to repay the government. The averred that the method or the manner in which their claims were considered violated their right to procedural due process so they requested review by the Health Care Finance Administration. William Blake, the Associate Regional Administrator of HFCA reviewed this case, noting unfair methods employed by Benso. He asked her to reopen the case or reaffirm her decision, which by the way, were his only options. She refused to reopen and thus reaffirmed her decision on August 27, 1984.

The Bushmans admitted they received a hearing but denied that got a "fair" one. They therefore refused to refund the money they thought they deservedly earned. The United States sued them in federal district court for repayment. The Bushmans, in their answer, claimed they were deprived of their right to due process of law embodied in the U.S. Constitution. They averred that the medical services they rendered were absolutely necessary.

The U.S. Government contended, via a Motion for Summary Judgment, that the district court only had jurisdiction under 28 U.S.C. § 1345 to enter a money judgment against the Bushmans; it denied that the court had subject matter jurisdiction to entertain their constitutional claims. On June 25, 1986 the district court (The Honorable Stephen N. Limbaugh, presiding) denied the United States' Motion for Summary Judgment. Trial was joined on September 16-17, 1986. The decision of the district court followed on March 5, 1987.

Judge Limbaugh opined that it did not have jurisdiction to consider whether the carrier erred in determining that the Bushmans were overpaid, i.e. the amount of the claims, but that it did have subject matter jurisdiction over the brothers' claims to consider whether the manner or method by which GALIC made its determination violated their constitutional right to due process. However, Judge Limbaugh ruled against the defendants, charging they did not prove their case that their constitutional rights were infringed. Accordingly, judgment was entered against Robert Bushman in the amount of $7,398.40 and against Richard Bushman in the amount of $9,047.04 with interest at the rate of 6.09 percent per annum until paid. On May 7, 1987 the district court amended its order of March 5, 1987 and entered judgment against Robert Bushman for $14,638.72 and Richard Bushman for $17,900.80 with interest at the rate of 6.09 percent per annum until paid.

The Bushmans, invoking jurisdiction under 28 U.S.C. Sec. 1291, appealed to the United States Court of Appeals, Eighth Circuit. That court affirmed the district court's judgment on December 9, 1988. It found that, contrary to the district court's conclusion, that the federal courts do not have subject matter jurisdiction to hear the Bushmans' claim so it concluded that it need not address the constitutional arguments of deprivation of due process raised by appellants. It affirmed the district court's judgment ordering that Robert Bushman pay $7,398.40 and that Richard Bushman pay $7,398.40 to the United States.

The Bushmans petitioned for a rehearing to the Court of Appeals, which it denied on January 18, 1989; hence this Petition for Writ of Certiorari.

REASONS FOR GRANTING THE WRIT

I. Method v. Determination of Amount

Title XVIII of the Social Security Act, 42 U.S.C. §§1395 *et seq.*, which is known as Medicare, provides health insurance for the aged and disabled. Its administered by the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS). Medicare is divided into two sections, Part A (with which we are not concerned) and Part B. The latter establishes a supplemental medical insurance program, voluntary in nature, which covers 80 percent of reasonable charges by doctors, as well as other medical health services (42 U.S.C. §§1395j-1395w). This claim of the Bushmans arises out of Part B.

The Part B program does not give comprehensive coverage. It is in the nature of a private medical insurance program that is partially subsidized by the federal government. Some services, as in the case of private insurance, are excluded from coverage, 42 U.S.C. §1395y, or are excluded for some other reason, 42 U.S.C. §§1395k, 1395l, 1395x. And, in some instances, Medicare specifies limits on payment for certain services, 42 U.S.C. §1395u(b)(3)(B); 42 C.F.R. §§405.501 *et seq.* This highly complex Act defines those services and items for which Part B reimbursements are to be made; an important limitation pertinent to this case is set forth in part as follows:

> Notwithstanding any other provision of this subchapter, no payment may be made under Part A or B of this subchapter or any expenses incurred for items or services—(a)(1) which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. 42 U.S.C. §1395y(a)(1); 42 C.F.R. §405.310(k)(l).

Congress authorized the Secretary of HHS, in administering Medicare, to contract with private health carriers like GALIC to

serve as agents of the Secretary in carrying out the functions of the Medicare Part B program. 42 U.S.C. §1395u(f); 42 C.F.R.§§421.1-421.5 and 421.200-421.205. GALIC, the Part B insurance carrier determined whether the Bushman's, or the claim of any doctor, met Part B guidelines, i.e. whether their services were covered (rendered to Part B beneficiaries and medically necessary 42 U.S.C. §1395u(b)(3)(B); 42 C.F.R. §405.501 *et seq.)* It is vital to stress that carriers are an agent of the U.S. Government in making coverage and reimbursement determinations, and, as such, are bound by Medicare Statutes, HHS regulations, and by manuals issued by the Secretary to be used by the carrier, see *Hatcher v. Heckler,* 772 F.2d 427, 428 (8th Cir. 1985). The GALIC carrier manual provided for claim forms to be sent to the Bushmans for them to fill out. Thus, this is a method governed by federal regulations, i.e. the method of sending out claims forms as provided for in the Secretary's carrier manuals.

If a claimant, like the Bushmans, is dissatisfied with the carriers initial determination that they were overpaid for uncovered services, he can request a full-blown hearing before a hearing officer in the employ of the carrier. 42 U.S.C. §1395u(b)(3)(c); 42 C.F.R. §§405.820-405.835. The Bushmans did request and receive such a hearing. As we have seen, they did not like the outcome. The hearing officer has the option to reopen the proceeding or affirm her decision, and when she reaffirms, the decision is final and binding. 42 C.F.R. §405.835. The United States avers that Congress did not authorize further administrative or judicial review of the hearing officer's decisions. 42 U.S.C. §1395ff(b); 42 C.F.R. §405.835. *United States v. Erika,* 456 U.S. 201, 203; 102 S.Ct. 1650, 1652 (1982); *Schweiker v. McClure,* 456 U.S. 188, 191; 102 S.Ct. at 1668 (1982).

The Court should grant the writ to review the question of whether the Bushmans' claim is a mere dispute over amount determination or a dispute over the method employed by the

Secretary in issuing regulations governing carrier activity in the administration of the Part B program. Appellants agree with the United States that mere amount determinations under Part B are not open to judicial review. It is obviously true the Bushmans are concerned over money but not a particular amount. They are not arguing over the issue of amount determinations, i.e. whether the hearing officer wrongly found against them on 209 out of 251 claims. All physician's disputes with HHS ultimately reflect financial concerns.

The Bushmans contend that the overpayment determinations made by GALIC were based on the failure of the podiatrists to list the referring physician's name and the date last seen on the claims forms as required by § 4120.1(3)(a) of the Medicare Carriers Manual, reprinted in 2 Medicare and Medicaid Guide (CCH) g 10, 291.01 (See copy of Respondent's brief as Appendix D in this petition.) As section 4120.1(3)(a) states: "claims for such routine services would show in item 7D of the HCFA-1490 [now 24D of the HCFA-1500] of the complicating systemic disease. Where these services were rendered by a podiatrist, this item should also include the name of the M.D. or D.O. who diagnosed the complicating condition. In those cases where active care is required, the approximate date the beneficiary was last seen by such physician must also be indicated." The Bushmans received these HCFA-1490 claim forms and filled them out. However, unlike 24D of the HCFA-1500 form which replaced the form HCFA-1490, (which was used between October 1979 and October 1981 by the Bushmans), HCFA 1490 did *not* contain a box for the referring physician's name and date the patient was last seen. The Bushmans certainly did not have access to the Medicare Carriers Manual; they didn't even know of its existence if access would have been had. They submitted their claim forms 1490 ignorant of the necessity of putting down the referring physician's name. Also, there were no instructions on the back of this form guiding them to set down the referring doctor's name. (See Appendix E which is a copy of Form HCFA-1490 and Appendix F

which is a copy of Form-1500). The Bushmans were asked to comply with a regulation whose implementing claim form they could not possibly adhere to. In essence, the Bushmans were ambushed. That is the gravamen of their claim. It is relevant to also mention that the Bushmans were unable to get a copy of the carrier's manual extant between 1979 and 1981 to see if indeed section 4120.1(3)(a) mentions form 1490 and the instruction to provide the name of the referring physician and date last seen. The United States never proved it existed but quoted, as did we, from the 1987 manual.

It is pertinent to point out that the Bushmans brought in a physician and a D.O. at the hearing and they testified they were the referring doctors in all these cases at issue. Benso, the hearing officer, was unmoved because the Bushmans didn't set down their names in the 1490 claim forms. That is why their claims were selected for review in the first place — before Benso conducted her hearing. Benso adamantly upheld the initial rejection of the great majority of the claims and allowed a few to make her actions appear fair. Now it is apparent that appellants can not attack the fairness of the hearing conducted by Benso even though it was patently unfair (as explained in detail in appellant's brief). The federal courts cannot review the carrier's *application* of the Secretary's regulations and its final determination by the hearing officer. *Kuritzky et al v. Blue Shield of Western New York, Inc., et al,* No. 87-0076-E, Slip op. (W.D. N.Y., February 16, 1988), *Hatcher* at 429. The federal courts apparently feel, that to review due process violations by carrier's employees, who act as agents of the federal government, would clog the courts with irate Part B payments claimants. True, the Bushmans have enveighed, do enveigh, against the unfairness and the caprice of the hearing officer who rejected all their witnesses and evidence. But that is not the point at which they mount their constitutional due process attack, because the court will not take jurisdiction over Medicare Part B amount determinations. *United States v. Erika,* at 203. To repeat, theirs is not a dispute over fee determinations by the

carrier. In their appellate brief, the Bushmans admittedly attacked the fairness of the "fair" hearings, i.e. the management of the hearing by the hearing officer, on due process grounds, for "judicial review of Medicare reimbursement decisions is governed by the Administrative Procedure Act, 5 U.S.C. § 701-06 (1982) which requires a court to set aside agency actions found to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law. . ." *Regents of University of California etc. v. Heckler,* 771 F.2d 1182, 1187 (1985). Benso, the hearing officer, just to cite one of many of her transgressions against due process, lost the transcript of the hearing, as well as her notes. 42 C.F.A. § 405,833 directs that "a record of the hearing shall be made. The testimony shall be transcribed . . . The record will also be transcribed and reproduced at the request of the party . . ." The Bushmans requested the transcript for use at trial but it could not be produced because Benso lost it, by her admission. This negligence on the part of an agent of the government is not "in accordance with the law." *Regents of the University of California v. Heckler, Ibid,* 1187. This one example of denial of due process at the hearing stage is cited to demonstrate that the appellants directed the initial phase of their two-pronged attack at the *application* of the Secretary's regulations by the carrier, i.e. they attacked the method by which their due process rights were taken away by the carrier. Then, in the second aspect of their attack, they charged that the method by which the Secretary acted to deny due process, in sending out faulty claim forms, was the primary cause of their dilemma. Appellants trusted in winning on both denials of due process, but if they failed on the one concerned with the unfair hearing, they certainly expected to prevail on the Secretary's negligent, arbitrary method, which can stand alone.

So the podiatrists' argument for review by this Court is mainly founded on its decision in *Bowen v. Michigan Academy of Family Physicians,* ____ U.S. ____, 106 S.Ct. 2133 (1986). Therein the court faced the question whether section 1395ii or

1395ff of the Medicare Act prohibited judicial review of regulations promulgated under Part B. The Court said there is a strong presumption of judicial review of administrative action where the right to due process is denied and held that Congress did not intend to bar judicial review of matters which Congress did not delegate to private insurance carriers, such as challenges to the Secretary's instructions and regulations and to the methodology implemented in deriving the amount of benefits. *Id.* at 2140. The Court said that section 1395ff(b)(1)(C) does not speak to challenges mounted against the *method* used to determine the amounts rather than the determinations themselves. *Id.* at 2138. The constitutionality or validity of the Secretary's instructions, rules, forms and methods are open to judicial review for such are not to be considered at all in a fair hearing by the hearing officer employed by the insurance carrier. *Id.* at 2138-2139. The Court then stated: "as a result, an attack on the validity of a regulation is not the kind of administrative action that we described in *Erika* as an amount of the Medicare payment to be made on a particular claim and with respect to which the Act impliedly denies judicial review." *Ibid,* at 2139.

Thus, to reiterate, the Court speaks only to a review of the Secretary's regulations and concomitant methods and not review of the carrier's application of these regulations and its final determination of fee amounts, for such determination is the sole issue the carrier's hearing officer can decide. The hearing officer can not pass upon constitutional defects in the regulations which guide her; she can only obey them.

Appellants attack the validity of the Secretary's regulations and instructions. Precisely, they challenge claim form HCFA-1490 which lacked the requisite instructions and boxes which were supposed to direct the health providers (e.g. the Bushmans) to insert the name of the referring physician and date the patient was last seen by the physican. This claim form HCFA-1490 was incorporated in § 4120.1(3)(a) of the Medicare

Carriers Manual. The claim form therefore does not conform to its own governing regulation. Thus, it is apodictic that the Secretary did not conform to her own regulations in issuing this defective claim form which, inherently, could not give due notice.

True, the Bushmans chastised Benso's unfair actions as constituting a denial of their due process rights (which rightly, or wrongly, have been found not to be reviewable by the courts based upon congressional intent) but theirs was a collateral attack against the carrier because the carrier, through its employee Benso, and, even earlier, through its employee who made the initial amount determination of overcharges, relied upon and applied the Secretary's regulations and instructions. The Secretary's promulgation of Section 4120.1(3)(a) with its attendant form HCFA-1490 constitutes a denial of Bushmans' right to due process, for due to the claim forms they filled out and submitted for payment, they lacked fair notice that they had the duty to name the referring doctors, even though they always used referring physicians with regard to these elderly patients in nursing homes, of whom almost all had peripheral vascular disease (a covered compensable affliction). Due to the submission of these claim forms, their claims were initially denied *well* before the hearing, so the hearing is after the fact, i.e. collateral. Thus, the Secretary, by issuing these incorrect forms to the Bushmans, in contravention of her own regulations, deprived them of their property (i.e. money) without due process of law.

The Court of Appeals, Eighth Circuit could not discern that the Bushmans were challenging the Secretary's instructions and regulations. Curiously, the Court of Appeals made no reference to appellants' cardinal case, *Bowen v. Michigan Academy of Family Physicians*. It doggedly adhered to the view that the "essence of the Bushmans' due process claim is that they received an unfair hearing." *Ibid*, p. 5 of the Court's December 9, 1988 order in this appendix. This is because much was made at the trial and in the brief of Benso's unfair handling of the hear-

ing but it was necessary to reveal her lamentable management of the hearing because she denied most of the Bushmans' claims *due* to the absence of the referring doctor on the 1490 claim forms they submitted. She did so in spite of all the evidence that the Bushmans presented; indeed she could see no further than the borders of those claim forms. Either the referring doctor's names were on them or not, despite the absence of boxes or instructions (or any warning newsletters sent before October, 1981). The faultily-fashioned forms issued by HHS commanded the hearing officer to rule as she did. It may well appear to the Court that appellants are enmeshed in tautology but they have a well-founded fear that the Court, like the appellate court, will overlook the crux of the matter — that, at bottom, they are challenging the validity, the constitutionality of the Secretary's instructions and regulations. Such challenge is not impliedly insulated from judicial review by 42 U.S.C. § 1395ff. *Michigan Academy of Family Physicians, Ibid* at 2140. They are challenging the constitutionality of the method of the amount determination, not the amount determinations themselves.

Furthermore, it should not disturb the Court that appellants' previously awarded benefits are at issue for in that sense the Bushmans' case is not like *Michigan Academy of Family Physicians.* It is like a later case which is distinguished from *Michigan Academy* in that, in the latter "the relief requested was purely prospective; the present case, however, was brought by an individual whose already awarded benefits were at issue. McCuin, however, has not sought review of the merits of her Medicare claim. Conceding that § 1395ff bars her from making such an argument, she has solely contested the propriety of the Secretary's reopening procedure. *Michigan Academy* makes no distinction between purely prospective challenges and challenges which have arisen in connection with a past claim but which are directed solely at the 'method' of determination. Nor does the Court's reasoning in that opinion give any grounds for

making such a distinction." *McCuin v. Secretary of Health and Human Services,* 817 F.2d 161 (1st Cir., 1987).

In addition, to allay any fear of a flood of claims ensuing if appellants are successful in getting this Court to review its claim, it is appropriate to stress that only podiatrists who used the 1490 claim form from 1979-1981 and were denied payment due to their justifiable ignorance because of a lack of fair notice would be favorably affected. The Bushmans' claim is probably sui generis anyway and it must be recalled that Congress is no longer worried about any deluge of claims because on October 21, 1986, it amended 42 U.S.C. § 1395ff to provide for judicial review of Part B Medicare determinations after all.

The appellants entreat this Court to hear their case. It is important to do so because their claim should be heard because of the obvious deprivation of due process by an inept governmental bureaucracy. This is a successor case to *Michigan Academy* and the Court should assume jurisdiction here as it did in that learned decision. At the very least, the Bushmans should be granted a new, *fair* hearing.

II. Collateral or Inextricably Intertwined?

Briefly, let us review the appellate court's decision that, in addition to the fact the Bushmans' complaint was really only one of not getting a fair hearing, or at bottom then, a squabble over mere amount determinations, even if it did "implicate the due process clause, it is so inextricably intertwined with the Bushmans' claims for benefits that it is unreviewable by the court." *Ibid* at p. 6. Naturally, appellants disagree. They cite the appellate court's own opinion where it held "that Congress did not intend for the jurisdictional limitations contained in the Medicare Act to apply to the Medicare Act in such a manner as to completely bar judicial consideration of a claim of denial of due process." *St. Louis University v. Blue Cross Hospital Service,* 537 F.2d 281, 292 (8th Cir., 1976). The appellate court countered that "any exception to the Medicare Act's jurisdic-

tional limitations, such as we found in *St. Louis University*, can have application only to cases where the constitutional claims relating to procedures are collateral to, and not 'inextricably intertwined with,' claims for entitlement.'' *Hatcher v. Heckler* at 431.

As the Bushmans have already amply demonstrated, they were forced to attack the actions and determinations of amounts by the hearing officer because her opinion was the ineluctable result of her reliance on the erroneous 1490 claim forms issued by her superior, the Secretary. Her opinion was collateral to, and not inextricably intertwined with, the Secretary's method of carrying out her regulations and instructions. Benso was merely the agent whose bounded duty it was to adhere to the form as embodied in the rule. Even though the form was not selfexplanatory (as it must be to be properly filled out by the Bushmans, who were unaware of the rule in the carrier manual), its instructions were set forth in the rule in the Carrier Manual, of which Benso has physical possession. The Regulation, which embodied such faulty form, then was defective ab initio, in and of itself. Benso was merely an implemental agent of the invalid claim form, which in turn, invalidated the rule, whose purpose as stated alone was quite legitimate. The claim form did not conform to its parent rule. The claim form, being invalid, invalidated the rule and rendered it inoperable. The claim form, and hence the rule, would be inherently invalid, even if it had never been utilized by the Bushmans, or Benso. Logic thus dictates that appellants' attack on the constitutionality of the rule, with its inherent contradiction, is a collateral attack which is not inextricably intertwined with petty amount determinations. An invalid rule does not command consequences, in a vacuum. The rule commanded the hearing officer to rule in a certain way if it was not obeyed; bad rules, like bad ideas, have bad consequences. Cause and effect are not inextricably intertwined, but they coexist. Due process rights cannot be violated until the flawed regulation invites unconstitutional consequences. A bad rule, or idea, (e.g. Hitler's

plan to exterminate inferior racial stocks) even if never acted upon, is, to reiterate, bad in itself but it is not unconstitutional (or genocidal) until it is acted upon by an agent. If the outcome here, the amount determination, is deemed inextricably intertwined with the Bushmans' primary target, the invalid rule, which ultimately caused the amount determination, then the Bushmans can receive no redress of the deprivation of their right to due process. The Queen of Hearts in Alice In Wonderland would deem such result a condign one. She would rule that one can not challenge due process violations by her hearing officer in applying the law, i.e. determining the amount based on the claim form, but, pari passu, she would rule that one also can not attack the invalid regulation as being unconstitutional at the outset because the amount determination is inextricably intertwined with the claim that her Secretary violated due process by issuing invalid rules, or vicariously broke her own rules. Perhaps this is a subtlety such as would have engrossed Duns Scotus but we trust he would have used his common sense and pronounced our attack on the Secretary's regulation(s) as a collateral one, thus enabling the court to take jurisdiction of this case. Then the constitutional issue of deprivation of the Bushmans' due process rights could be determined.

CONCLUSION

The Court should grant the writ to review whether the Court of Appeals had jurisdiction to hear this case, and if it did, whether the appellants' right to due process under the Fifth Amendment was denied.

The Court should grant the writ to review whether the Court of Appeals, as well as the district court, had jurisdiction to hear this case, and if it did, whether appellants' right to due process under the Fifth Amendment was denied.

Respectfully submitted,

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APPENDIX

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 87-1759

Appeals from the United States District Court
for the Eastern District of Missouri

United States of America,
Appellee,

v.

Richard D. Bushman, D.P.M.,
Appellant.

* * * *

United States of America,
Appellee,

v.

Robert L. Bushman, D.P.M.,
Appellant.

Submitted: September 20, 1988

Filed: December 9, 1988

Before MCMILLIAN, Circuit Judge, BRIGHT, Senior Circuit Judge and FAGG, Circuit Judge.

BRIGHT, Senior Circuit Judge.

These appeals follow actions brought by the United States to recover from appellants Richard D. Bushman and Robert L. Bushman overpayments made pursuant to Part B of the Medicare Act. The Bushmans defend their refusal to refund the overpayments by alleging that the manner in which their claims were considered violated their procedural due process rights. The district court[1] found in favor of the United States, holding that to the extent the Bushmans sought review of Medicare Part B determinations, the court lacked jurisdiction. The court further held that, although it did have jurisdiction over the Bushmans' federal constitutional claim, the Bushmans failed to prove any constitutional deprivation. The court thereupon ordered the Bushmans to refund the overpayments to the United States. This appeal followed and, for the reasons set forth below, we affirm.

I. BACKGROUND

Richard and Robert Bushman are podiatrists who, between October 1979 and October 1981, provided medical treatment to Medicare beneficiaries under Part B of Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.*, commonly known as the Medicare program. The patients assigned their claims for benefits to the Bushmans pursuant to 42 U.S.C. § 1395u(b)(3)(B)(ii) and the Bushmans, in turn, filed requests for payment with General American Life Insurance Company (General American), a carrier authorized by the Secretary of Health and Human Services to make such payments.

By letters dated December 22, 1981, and December 27, 1981, Phyllis Seka, Director of Medicare Program Control at General American, advised the Bushmans in writing that a full scale

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[1] The Honorable Stephen N. Limbaugh, United States District Court for the Eastern and Western Districts of Missouri.

review of a statistically valid sample of their claims revealed that Richard Bushman had received $11,784.00 in overpayments and that Robert Bushman had received $9,139.20 in overpayments. Ms. Seka requested refunds of the overpayments.

The Bushmans requested a hearing on General American's determination pursuant to 42 U.S.C. § 1395u(b)(3)(C) and 42 C.F.R. §§ 405.801 *et seq.* Hearing Officer Linda Benso conducted the hearing at which she considered the 251 claims submitted by the Bushmans between October 1979 and October 1981, and concluded that General American had properly paid forty-two of those claims but had improperly paid the remaining 209 claims. Benso thus adjusted Richard Bushman's overpayment determination to $9,047.04 and Robert Bushman's overpayment determination to $7,484.00.[2]

The Bushmans requested review by the Health Care Finance Administration (HCFA). The Associate Regional Administrator of HCFA, William Blake, after reviewing the documents submitted, requested that General American either reopen the case or reaffirm its decision. Benso reaffirmed her decision on August 27, 1984, and Blake so advised the Bushmans.

The Bushmans, nevertheless, refused to refund the overpayments, and on August 1, 1985, the United States instituted these recovery actions. The Bushmans answered, defending their refusal to pay by contending that Hearing Officer Benso conducted an unfair hearing on determination of their benefits and, thus, denied the Bushmans their due process rights.

After a trial to the district court, Judge Limbaugh, citing *United States v. Erika, Inc.*, 456 U.S. 201, 203 (1981), held that to the extent the Bushmans sought review of General

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[2] General American later adjusted the determination of Robert Bushman's overpayments to $7,398.40.

American's Medicare Part B determinations, it was without jurisdiction to hear their complaint. The district court proceeded, however, relying on *St. Louis University v. Blue Cross Hospital Service,* 537 F.2d 281, 292 (8th Cir. 1976), and *Hatcher v. Heckler,* 772 F.2d 427, 429-31 (8th Cir. 1985), to consider the Bushmans' claims to the extent that they challenged, as violative of their federal due process rights, the manner in which General American made its determinations. The court, nevertheless, held that the Bushmans failed to prove any due process violation and ordered Richard Bushman to refund overpayments totaling $9,047.04 and ordered Robert Bushman to refund overpayments totaling $7,398.40.

This appeal followed.

II. DISCUSSION

Our review of this case must necessarily begin with an inquiry into the court's subject matter jurisdiction. The district court concluded that it had jurisdiction over the constitutional claims. We disagree.

Part B of the Medicare Act is a voluntary supplemental insurance program covering, generally, eighty percent of the reasonable charges for physician's services, as well as certain other medical and health benefits. Benefits determinations under Part B are made by the carrier with whom the Secretary of health and Human Services contracts to administer the program, in this case, General American. Claimants are entitled to *de novo* review of any benefits determination with which they are dissatisfied. 42 C.F.R. §§ 405.807-405.812. If the amount in controversy is $100.00 or more, the dissatisfied claimant is entitled to an oral evidentiary hearing. 42 U.S.C. § 1395u(b)(3)(C); 42 C.F.R. §§ 405.820-405.835. Unless the carrier or hearing officer decides to reopen the proceeding, this decision is final and binding upon the parties. 42 C.F.R. § 405.835. No further review of the carrier's determination of the

amount of benefits payable under Part B is contemplated by the Act. *Erika,* 456 U.S. at 206-08.

The Bushmans, however, claim that they are not seeking review of the amount of General American's benefits determinations, but are seeking their constitutionally guaranteed right to a fair hearing before an unbiased hearing officer and that, thus, this court has jurisdiction to hear their claims. The Bushmans cite our opinion in *St. Louis University,* 537 F.2d at 292, where we held "that Congress did not intend for [the jurisdictional limitations contained in the Medicare Act] to apply to the Medicare Act in such a manner as to completely bar judicial consideration of a claim of denial of due process." In *Hatcher,* however, we carefully limited the reach of *St. Louis University* and made clear that not every due process claim is cognizable by the courts. "Any exception to [the Medicare Act's jurisdictional limitations], such as we found in *St. Louis University,* can have application only to cases where the constitutional claims relating to procedures are collateral to, and not 'inextricably intertwined with,' claims for entitlement." *Hatcher,* 772 F.2d at 431 (citation omitted).

The essence of the Bushmans' due process claim is that they received an unfair hearing. They claim in their answers to the Government's complaints that Benso based her decision on evidence that was inadmissible, incompetent and highly prejudicial to the Bushmans; that Benso never concluded that the services rendered by the Bushmans were not medically necessary; and that Benso was biased against the Bushmans and engaged in a scheme to build evidence against them. In essence, they claim that Benso's decision was wrong and that they were entitled to payment for the services rendered. Their appellate brief is essentially an argument as to the validity of their claims.

These are precisely the kinds of claims we cannot review. Even though the Bushmans couch their claims in constitutional language, *i.e.*, their due process right to a fair hearing, the im-

port of their allegations is clear: they seek our review of the validity of their claims by asserting that the result reached was error because of Benso's alleged bias and incompetence. At bottom, this is simply a claim that the Bushmans were entitled to the Medicare Part B benefits they received, a claim not cognizable by this court. *Erika,* 456 U.S. at 206-08. Further, to the extent that such a claim does implicate the due process clause, it is so inextricably intertwined with the Bushmans' claims for benefits that it is unreviewable by this court. *See Heckler v. Ringer,* 466 U.S. 602, 614 (1984); *Hatcher,* 772 F.2d at 431. Were we to review such a claim, we would be opening the door to every dissatisfied Medicare Part B claimant who believes the decision maker acted unfairly and made a decision based on the wrong evidence. This we cannot do in light of the congressional mandate to place the ultimate discretion for claims determinations in the Medicare carrier. *See Hatcher,* 772 F.2d at 429 (the legislative history clearly supports the proposition that Congress limited jurisdiction over Part B claims in order to protect the courts from the inevitable overloading which would surely result if every dissatisfied Medicare claimant appealed to the federal courts). Such claims are so inextricably intertwined with General American's benefits determinations that we cannot decide them without exceeding our jurisdiction.

III. CONCLUSION

Because the federal courts lack subject matter jurisdiction over the Bushmans' claims, we need not address the constitutional arguments raised. We affirm the district court judgment ordering Richard Bushman to pay $9,047.04 and Robert Bushman to pay $7,398.40 in favor of the United States.

A true copy.

ATTEST:

Clerk, U.S. Court of Appeals, Eighth Circuit.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 87-1759EM

Appeal from the United States District Court
for the Eastern District of Missouri.

United States of America,
Appellee,

vs.

Richard D. Bushman, D.P.M. and
Robert L. Bushman, D.P.M.,
Appellants.

Appellants' petition for rehearing has been considered by the Court and is denied.

January 18, 1989

Order entered at the Direction of the Court:

/s/ Robert D. St. Vrain

Clerk, U. S. Court of Appeals, Eighth Circuit.

APPENDIX C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 85-1768 C (5)
No. 85-1769 C (5)

United States of America,
Plaintiff,

vs.

Richard D. Bushman and Robert L. Bushman,
Defendants.

ORDER

In accordance with the Memorandum filed today,

IT IS HEREBY ORDERED that judgment is entered in favor of plaintiff United States and against defendant Robert L. Bushman on the merits in the amount of $7,398.40 with interest at the rate of 6.09 per annum from this date until paid.

IT IS FURTHER ORDERED that judgment is entered in favor of plaintiff United States and against defendant Richard D. Bushman on the merits in the amount of $9,047.04 with interest at the rate of 6.09 per annum from this date until paid.

IT IS FURTHER ORDERED that the parties may submit additional documentation and information by affidavit and may submit memoranda within ten (10) days from the date of this order concerning plaintiff's claim for pre-judgment interest.

Dated this 5th day of March, 1987.

/s/ Stephen N. Limbaugh
United States District Judge

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

No. 85-1768 C (5)
No. 85-1769 C (5)

United States of America,
Plaintiff,

vs.

Richard D. Bushman and Robert L. Bushman,
Defendants.

MEMORANDUM

The United States contends in these consolidated cases that defendants Richard D. Bushman, D.P.M. and Robert L. Bushman, D.P.M. received overpayments for services they rendered to patients under Medicare from October 1979 through October 1981. Plaintiff, through its agent, the General American Life Insurance Company, conducted an administrative review of some of defendants' claims and determined that they had received overpayments. The United States asserts that defendants cannot challenge this administrative decision and must reimburse the government for these overcharges.

As a defense, defendants contend that the manner in which the United States and its agents considered the propriety of their charges violated their procedural due process rights. Before trial, the United States moved for summary judgment, contending that this Court does not have subject matter jurisdiction over the defendants' constitutional challenge to the government's overpayment determination. On June 25, 1986, the Court denied plaintiff's motion for summary judgment, finding that under *St. Louis University v. Blue Cross Hospital Service*, 537 F.2d 283, 291-92 (8th Cir. 1976), the Court could consider

the Bushmans' constitutional arguments. The Court also held that the decisions of the Supreme Court in *Heckler v. Ringer,* 466 U.S. 602 (1984), and the Eighth Circuit in *Hatcher v. Heckler,* 772 F.2d 427 (8th Cir. 1985), did not undercut the viability of *St. Louis University.*

The United States then moved for relief from the Court's order, citing *Bowen v. Michigan Academy of Family Physicians,* 106 S.Ct. 2133 (1986). After determining that the second motion raised no new issues, the Court denied that motion. The United States continues to urge that the Court does not have subject matter jurisdiction over defendants' constitutional challenges to the overpayment determination.

Findings of Fact

Defendants Richard D. Bushman and Robert L. Bushman provided medical treatment to beneficiaries between October 1979 and October 1981 under Part B of the Federal Medicare Program, 42 U.S.C. §§1395 *et. seq.* As payment for these services, defendants received assignments of the beneficiaries' claims under 42 U.S.C. §1395u(b)(3)(B)(ii) and filed requests for payment with General American Life Insurance Company, the designated agent of the Secretary of Health and Human Services.

Phyllis Seka, director of General American's Medicare Program Control Division, informed defendants in letters dated December 22, 1981 and December 27, 1981 that they had received overpayments for services provided from October 1979 through October 1981. In particular, the letters informed the Bushmans of the carrier's determination that Richard Bushman had received overpayments totaling $11,784.00 and Robert Bushman had received overpayments of $9,139.20. She also stated that the carrier had made a full scale review of a statistically valid sample of their claims and had reopened these claims as provided in 42 C.F.R. 450.841.

The defendants requested a hearing on the carrier's initial determination, and on March 19, 1982 the designated hearing officer, Linda Benso, conducted a hearing pursuant to 42 U.S.C. 1395(b)(3)(C) and 42 C.F.R. §§405.801 *et.seq*. At this hearing, Benso considered the validity of 251 claims submitted by the Bushmans during the relevant time period. Benso played no role in selecting these claims for review and had no knowledge of the outcome of the previous reviews the company had conducted. She found that the carrier had properly paid forty-two of the claims, but had improperly paid the balance of the claims. In a letter dated April 28, 1982, Benso informed defendants that Robert Bushman had received overpayments totaling $7,484.00 and Richard Bushman had received overpayments totaling $9,047.04.

The defendants then requested that the carrier refer their case to the Health Care Financing Administration (HCFA). By letter dated January 4, 1983, Liola A. Yobley, Supervisor of the Medicare Program Control Division of General American, informed Richard Bushman that it would refer his case to the HCFA. The carrier adjusted its earlier determination and held that Robert Bushman had received overpayments totaling $7,398.40. It then agreed to refer his case to the HCFA for consideration along with his brother's case. On July 9, 1984, William Blake, Associate Regional Administrator of the HCFA, requested that General American either reopen the case or reaffirm its decision. After receiving the carrier's response to this request, Blake informed defendants' attorney on August 27, 1984, that the carrier had reaffirmed its decision.

Defendants' sole challenge to plaintiff's overpayment determination rests on their assertion that the March 19, 1982 hearing conducted by Linda Benso was unfair and constituted a denial of their due process rights. While they attempted to prove at trial that Benso's decision was factually incorrect, they did not substantiate their allegations of constitutional improprieties. In particular, they did not prove that Benso con-

sidered evidence outside the administrative record. Although Benso and Seka were friends, Benso did not receive any information from Seka on which she relied in making her decision. The only information she received from Seka concerned the sampling technique the carrier used when determining that the Bushmans had received overpayments. In fact, Benso asked Seka about this technique at the request of defendants' attorney. Seka did not attempt to influence Benso's decision and Benso based her determination solely on information received during the hearing and the applicable regulations.

The defendants also assert that they did not have notice of the basis on which Benso would eventually base her decision. However, Benso informed the Bushmans before the hearing that she would review their claims to determine whether they were for medically necessary treatment. She also identified the claims she would review and provided defendants' attorney with the regulations that would govern her decision.

Conclusions of Law

The Court does not have jurisdiction to consider any contention that the carrier erred in determining that the Bushmans received overpayments, *U.S. v. Erika,* 456 U.S. 201, 203 (1981), but does have jurisdiction over defendants' claim that the manner in which the carrier made this determination violated their federal constitutional due process rights. *St. Louis University,* 537 F.2d at 292, *see also Hatcher v. Heckler,* 772 F.2d at 429-431. However, the Bushmans did not prove that Benso based her decision on information outside the record or that she was biased. In addition, defendants did not prove that they did not have adequate notice of the grounds on which Benso would ultimately base here decision. As a result, due to the failure of defendant's proof, the Court will not consider the exact requirements of procedural due process in the context of a review by a carrier of the medical necessity of Part B Medicare payments.

The reaffirmation by the carrier of its determination that Robert Bushman had received overpayments totaling $7,398.40 and that Richard Bushman had received overpayments totaling $9,047.04 was a final decision under 42 U.S.C. §1395(b)(2) and 42 C.F.R. §405.835. As a result, the Court cannot review the validity of this decision and must enter judgment for plaintiff in these amounts. *Erica,* 456 U.S. at 203. The government contends that it should receive pre-judgment interest on these amounts under 42 C.F.R. 405.376 from December 27, 1981, the date on which it first demanded reimbursement for the overpayments. But, the record does not contain enough information for the Court to make an award of pre-judgment interest under this regulation. The Court will allow the parties to submit additional information by affidavit and briefs on this issue as provided in the accompanying order.

Dated this 5th day of March, 1987.

/s/ Stephen N. Limbaugh
United States District Judge

APPENDIX D

[¶ 10,291.01] Application of Foot Care Exclusions to Physicians' Services
[*Medicare Carriers Man.*, § 4120.1]

a. Claims for such routine services would show in item 7D of the HCFA 1490 [now 24D of the HCFA 1500] the complicating systemic disease. Where these services were rendered by a podiatrist this item should also include the name of the M.D. or D.O. who diagnosed the complicating condition. In those cases where active care is required, the approximate date the beneficiary was last seen by such physician must also be indicted.

APPENDIX E

REQUEST FOR MEDICARE PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back — **Type or Print Information**)

Form Approved
OMB No. 066-R-0012

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510)

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

When completed, send this form to:
General American Life Insurance Co.
P.O. Box 505
St. Louis, Missouri 63166

Copy from YOUR OWN HEALTH INSURANCE CARD *(See example on back)*

1 Name of patient (First name, Middle initial, Last name)

2 Health insurance claim number *(Include all letters)* 494078764 D

☐ Male ☑ Female

3 Patient's complete mailing address (including Apt. no.) City, State, ZIP Code

Telephone Number

4 Describe the illness or injury for which you received treatment *(Always fill in this item if your doctor does not complete Part II below)*

Was your illness or injury connected with your employment?

☐ Yes ☐ No

5 If any of your medical expenses will be or could be paid by another insurance organization or government agency, show below

Name and address of organization or agency

Policy or Identification Number

Note: If you **Do Not** want information about this Medicare claim released to the above upon its request, check (X) the following block ☐

6 I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

SIGN HERE ➡ Signature of patient *(See instructions on reverse where patient is unable to sign)* Estelle M. Hensler

Date signed

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given (if lab service, indicate if automated) — Procedure Code	D. Nature of illness or injury requiring services or supplies	E. Charges (if related to unusual circumstances explain in 7C)	Leave Blank
				$	

8 Name and address of physician or supplier *(Number and street, city, State, ZIP code)*

Telephone No.

Physician or supplier code

9 Total charges $

10 Amount paid $

11 Any unpaid balance due $

12 Assignment of patient's bill

➡ ☐ I accept assignment *(See reverse)* ☐ I do not accept assignment.

13 Name and address of person or facility where services were furnished *(Complete if outside your own office or patient's residence).*

14 Signature of physician or supplier (I certify that the statements under Physicians' Notes on the reverse apply to this bill and are made a part hereof.)

Date Signed

O—Doctor's Office
IL—Independent Laboratory
H—Patient's Home *(If portable X-ray services, identify the supplier)*
IH—Inpatient Hospital
SNF—Skilled Nursing Facility
OH—Outpatient Hospital
OL—Other Locations
NH—Nursing Home

FORM HCFA-1490(2) (1-78) (FORMERLY SSA-1490(2))

Department of Health, Education and Welfare—Health Care Financing Administration

BEST AVAILABLE COPY

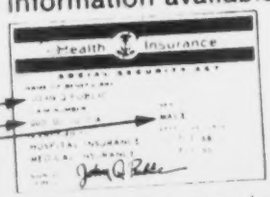
HOW TO FILL OUT YOUR MEDICARE FORM

There are two ways that Medicare can help pay your doctor bills

One way is for Medicare to pay your doctor.—If you and your doctor agree, Medicare will pay the doctor directly. This is the assignment method. You do not submit any claim; the doctor does. All you do is fill out Part I of this form and leave it with your doctor. Under this method the doctor agrees to accept the charge determination of the Medicare carrier as the full charge for covered services; you are responsible for the deductible, coinsurance, and non-covered services. Please read Your Medicare Handbook to help you understand about the deductible and coinsurance.

The other way is for Medicare to pay you.—Medicare can also pay you directly—before or after you have paid your doctor. If you submit the claim yourself, fill out Part I and ask your doctor to fill out Part II. If you have an itemized bill from the doctor, you may submit it rather than have the doctor complete Part II. (This form, with Part I completed by you, may be used to send in several itemized bills from different doctors and suppliers.) Bills should show who furnished the services, **the patient's name and number,** dates of services, where the services were furnished, a description of the services, and charges for each separate service. It is helpful if the diagnosis is also shown. Then mail itemized bills and this form to the address shown in the upper left-hand corner. If no address is shown there, use the address listed in Your Medicare Handbook—or get advice from any social security office.

Notice: It is important to keep a record of your claim in case you ever want to inquire about it. Before you send it in, write down the date you mailed it, the services you received, the date and charge for each, and the name of the doctor or supplier who performed the services. Have this information available when you inquire about a claim.



SOME THINGS TO NOTE IN FILLING OUT PART I
(Your doctor will fill out Part II.)

1 & **2** Copy the name and number and indicate your sex exactly as shown on your health insurance card. Include the letters at the end of the number.

3 Enter your mailing address and telephone number, if any.

4 Describe you illness or injury.
Be sure to check *one of the two boxes.*

5 If you have other health insurance or expect a welfare agency to pay part of the expenses, complete item 5.

6 Be sure to sign your name. If you cannot write your name, sign by mark (X), and have the signature witnessed. The witness's signature and address must also be shown in item 6.
If you are filing the claim for a Medicare beneficiary, in item 6 enter the patient's name and write "By," sign your name and enter your address in this space, show your relationship to the patient, and explain why the patient cannot sign. (If the patient has died, the survivor should contact any social security office for information on what to do.)

COLLECTION AND USE OF MEDICARE INFORMATION

We are authorized by the Health Care Financing Administration to ask you for information needed in the administration of the Medicare program. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act, as amended.

The information we obtain to complete your Medicare claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information about the Medicare benefits you have used to a hospital or doctor.

With one exception, which is discussed below, there are no penalties under social security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workmen's compensation will pay for the treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.

IMPORTANT NOTES FOR PHYSICIANS AND SUPPLIERS

Item 12: In assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the carrier, if this is less than the charge submitted. If the physician or supplier does not want Part II information released to the organization named in item 5, the physician or supplier should write "No further release" in item 7C following the description of services.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare regulations.

For services to be considered as 'incident to' a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his employee, 2) there was a covered physician's service rendered of which the other services are an integral, although incidental part, 3) they must be of kinds commonly furnished in physicians' offices, and 4) the services of nonphysicians must be included on the physicians' bills.

Notice: Anyone who misrepresents or falsifies essential information to receive payment from federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal laws.

APPENDIX F

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

DO NOT STAPLE IN BAR AREA

[redacted]

FOR **MEDICARE** MAIL TO:
GENERAL AMERICAN LIFE INSURANCE CO.
P.O. BOX 14924
ST. LOUIS, MO 63178

FOR **MEDICAID** MAIL TO:
G.A.C.
P.O. BOX 5600
JEFFERSON CITY, MO 65102

☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ OTHER

PATIENT & INSURED (SUBSCRIBER) INFORMATION

Form Approved OMB No. 0938-0008

1. PATIENT'S NAME *(First name, middle initial, last name)*	2. PATIENT'S DATE OF BIRTH	3. INSURED'S NAME *(First name, middle initial, last name)*
4. PATIENT'S ADDRESS *(Street, city, state, ZIP code)* TELEPHONE NUMBER	5. PATIENT'S SEX ☐ MALE ☐ FEMALE 7. PATIENT'S RELATIONSHIP TO INSURED SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐	6. INSURED'S I.D. MEDICARE OR MEDICAID NO. *(Include any letters)* 8. INSURED'S GROUP NO. *(Or Group Name)*
9. OTHER HEALTH INSURANCE COVERAGE ☐ YES ☐ NOT APPLICABLE/COVERAGE DENIED Enter Name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number	10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO B. AN ACCIDENT ☐ AUTO ☐ OTHER	11. INSURED'S ADDRESS *(Street, city, state, Zip code)*
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE *(Read back before signing)* I Authorize the Release of any Medical Information Necessary to Process the Claim and Request Payment of MEDICARE Benefits Either to Myself or to the Party Who Accepts Assignment Below. *SIGNED* *DATE*		13. *I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW* *SIGNED (Insured or Authorized Person)*

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)		15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ YES ☐ NO	16a. IF EMERGENCY CHECK HERE ☐
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM	THROUGH	DATES OF PARTIAL DISABILITY FROM	THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE *(e.g. public health agency)*			20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED	DISCHARGED
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*			22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? ☐ YES ☐ NO	CHARGES:

23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC or DX CODE

1.
2.
3.
4.

23B EPSDT ☐ SCREEN ☐ REFERRAL

FAMILY PLANNING ☐ YES

PRIOR AUTHORIZATION NO. _____

24. A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN TOS	PROCEDURE CODE (IDENTIFY:)	*(Explain Unusual Services or Circumstances)*	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. REMARKS/PRIOR AUTHORIZATION	H. F. P. OR EPSDT

25. SIGNATURE OF PHYSICIAN OR SUPPLIER *(I certify that the statements on the reverse apply to this bill and are made a part hereof)* SIGNED DATE	26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) ☐ YES ☐ NO 30. YOUR SOCIAL SECURITY NO.	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
32. YOUR PATIENT'S ACCOUNT NO.	33. YOUR EMPLOYER I.D. NO.	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO. 4 01-48 RICHARD D BUSHMAN DPM 10430 PAGE AVENUE OVERLAND MO 63132 I.D. NO. R6USH132 0006211111		

REMARKS:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 5-80 APPROVED BY THE HEALTH CARE FINANCING ADMINISTRATION & CHAMPUS Form HCFA-1500 (5-80) Form CHAMPUS-501

GALIC 1500C2(5-83)

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program and renders payment for health benefits provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured," i.e., items 3, 6, 7, 8, 9 and 11.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE AND CHAMPUS)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as 'incident' to a physician's professional services, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536).

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE AND CHAMPUS INFORMATION

We are authorized by HCFA and CHAMPUS to ask you for information needed in the administration of the Medicare and CHAMPUS programs. Authority to collect information is in section 205 (a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086.

The information we obtain to complete Medicare and CHAMPUS claims is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare or CHAMPUS and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards and other organizations or Federal agencies as necessary to administer the Medicare and CHAMPUS programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

With the one exception discussed below, there are no penalties under Social Security or CHAMPUS law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of Medicare or CHAMPUS claims. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workers' compensation will pay for treatment. Section 1877 (a) (3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and Medical Assistance Program and to furnish information regarding any payments claimed for providing such services as the State Agency, its designee, or Health and Human Services may request. I further agree to accept, as payment in full, subject to audit, the amount paid by the Medicaid (Medical Assistance) program for those claims submitted for payment under that program, with the exception of authorized deductibles, coinsurance, copayment and spenddown.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that (1) the services listed on the reverse side were medically indicated and necessary to the health of this patient and were personally rendered by me or under my personal direction, (2) the charges for such services are just, unpaid, actually due according to law and program policy and not in excess of regular fees; (3) the information provided on the reverse side of this claim is true, accurate and complete. I agree to comply with the provisions of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

I understand that payment and satisfaction of this claim will be from Federal and/or State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Supreme Court, U.S.
FILED
JUL 6 1989
JOSEPH F. SPANIOL, JR.
CLERK

No. 88-1808

In the Supreme Court of the United States

OCTOBER TERM, 1989

RICHARD D. BUSHMAN AND
ROBERT L. BUSHMAN, PETITIONERS

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTION PRESENTED

Whether the appeals court erred in holding that it lacked jurisdiction over a claim that the Secretary of Health and Human Services violated petitioners' due process rights by failing to give adequate notice of the requirements for filing a valid Medicare claim.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. A1-A6) is reported at 862 F.2d 1327. The memorandum opinion of the district court (Pet. App. A9-A13) is reported at 661 F. Supp. 266.

JURISDICTION

The judgment of the court of appeals was entered on December 9, 1988. A petition for rehearing was denied on January 18, 1989 (Pet. App. A7). The petition for a writ of certiorari was filed on April 18, 1989. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Medicare Part B is a voluntary supplemental insurance program that provides reimbursement for physicians' and various related ancillary services (42 U.S.C. 1395*l*). See Medicare Act, 42 U.S.C. 1395j-1395w (1982 & Supp. IV 1986). Private insurance carriers administer Part B benefits under contracts with the Secretary of Health and Human Services (HHS) (42 U.S.C. 1395u(a)(1)). The carrier reimburses Medicare patients, or their providers as assignees, for 80% of the "reasonable charges" for reimbursable services, as determined by the carrier in accordance with the Medicare statute and regulations promulgated by the Secretary (42 U.S.C. 1395*l*).

The Medicare statute provides for "a fair hearing by the carrier" if a dispute arises concerning the amount of reimbursement due a Medicare provider (42 U.S.C. 1395u(b)(3)(C)). During the period pertinent to this dispute the statute did not provide for administrative or judicial review of the carrier's determination as to amounts of reimbursement payable under Medicare Part B. See 42 U.S.C. 1395ff.

Limited coverage is available for services provided by podiatrists to Medicare beneficiaries enrolled under Part B. Section 4120.1(3) of the *Medicare Carriers Manual* (1978) [hereinafter *Medicare Carriers Manual*], in the version that applies to this case (see App., *infra*, 1a-2a), excludes Medicare coverage for routine foot care provided to healthy individuals, but permits "[p]ayment * * * for routine-type foot care * * * when the patient has a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous." [1]

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[1] Section 4120.1(3)(a) also provides that (App., *infra*, 2a):

> Claims for such routine services would show in item 7D of the SSA-1490 the complicating systemic disease. Where these services

2. Richard and Robert Bushman are podiatrists who administered foot care to Part B Medicare beneficiaries between October 1979 and October 1981. Patients assigned their claims for reimbursement to the Bushmans pursuant to 42 U.S.C. 1395u(b)(3)(B)(ii) and the Bushmans, in turn, filed requests for payment with the Medicare carrier authorized to make such payments. The carrier paid all of the claims in full. After a review by the carrier of a statistically valid sample of the Bushmans' claims, however, it was determined that there was insufficient documentation of the medical necessity of the treatment administered on 251 claims. The carrier found that Richard Bushman had received $11,784.00 in overpayments and that Robert Bushman had received $9,139.20 in overpayments, and requested refunds (Pet. 2-3).

The Bushmans requested a hearing pursuant to 42 U.S.C. 1395u(b)(3)(C) and 42 C.F.R. 405.801 *et seq.*, on the carrier's initial determination. Prior to the hearing, the hearing officer identified the 251 disputed claims, informed the Bushmans that the overpayment determination had been based on inadequate documentation of the patients' medical condition, and provided a copy of the regulations that governed the decision, including Section 4120.1(3)(a) of the *Medicare Carriers Manual*. See Gov't C.A. Br. 9-10; Pet. App. A12.

At the hearing, the Bushmans were afforded an opportunity to substantiate their claims. They introduced testimony by ~~four~~ physicians who had examined the patients, or the records of patients, for whom claims had been re-

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were rendered by a podiatrist this item should also include the name of the M.D. or D.O. who diagnosed the complicating condition. In those cases where active care is required, the approximate date the beneficiary was last seen by such physician must also be indicated.

jected, and they submitted charts on 35 of the patients. See App., *infra,* at 4a-5a (August 7, 1984 letter reaffirming Medicare Carrier Fair Hearing decision [hereinafter August 7 letter]). On the basis of the evidence submitted by the Bushmans at the hearing, the hearing officer determined that 42 of the Bushmans' claims were properly paid and that the balance of the claims were improperly paid (Pet. App. A11). Accordingly, the hearing officer reduced the overpayment determinations to $9,047.04 and $7,484.00, respectively (*ibid.*).

The Bushmans sought review of the hearing officer's decision from the Health Care Finance Administration (HCFA) of the Department of Health and Human Services. HCFA requested the carrier either to reopen the case or to reaffirm its decision (Pet. App. A3). The carrier reaffirmed its decision (*ibid.*), which became the final decision of the Secretary. See 42 C.F.R. 405.835. Medicare demanded refunds of the overpayments, and the Bushmans refused (Pet. App. A3).

3. The United States brought this action against the Bushmans to collect the Medicare overpayments. The Bushmans defended the action before the district court by claiming that the unfair manner in which their claims were evaluated by the hearing officer, and the inadequate notice they received of the basis for her decision, denied them due process of law (Pet. App. A12). Relying on *United States* v. *Erika, Inc.*, 456 U.S. 201, 203 (1981), the district court held that it did not have jurisdiction to "consider any contention that the carrier erred in determining that the Bushmans received overpayments" (Pet. App. A12), but that it did have jurisdiction over the claim "that the manner in which the carrier made this determination violated their federal constitutional due process rights" (*ibid.* (citations omitted)). With respect to the latter claim, the court

concluded that there was no due process violation because "defendants did not prove that they did not have adequate notice of the grounds on which [the hearing examiner] would ultimately base [her] decision" (*ibid.*). Judgment was entered against the Bushmans for the Medicare overpayments of Part B benefits as determined in the carrier's final decision (Pet. App. A13).

3. The Eighth Circuit affirmed the judgment against the Bushmans (Pet. App. A1-A6), but disagreed with the district court concerning jurisdiction over the Bushmans' due process claim. The court took note of the Bushmans' argument that "they are not seeking review of the amount" of benefits, but "are seeking their constitutionally guaranteed right to a fair hearing before an unbiased hearing officer" (Pet. App. A5). The court nevertheless concluded that review of their claims was unavailable under Section 1395ff of the Medicare Act, explaining that "[e]ven though the Bushmans couch their claims in constitutional language" (Pet. App. A5),

> [t]he essence of the Bushmans' due process claim is that they received an unfair hearing. * * * [T]hey seek our review of the validity of their claims by asserting that the result reached was error because of [the hearing officer's] alleged bias and incompetence. At bottom, this is simply a claim that the Bushmans were entitled to the Medicare Part B benefits they received, a claim not cognizable by this court. *Erika*, 456 U.S. at 206-08.

(Pet. App. A5-A6). The court added that, "to the extent that [the] claim does implicate the due process clause, it is so inextricably intertwined with the Bushmans' claims for benefits that it is unreviewable by this court" (Pet. App. A6), citing *Heckler* v. *Ringer*, 466 U.S. 602, 614 (1984), and *Hatcher* v. *Heckler*, 772 F.2d 427, 429-431 (8th Cir. 1985).

ARGUMENT

Petitioners seek review from this Court on the narrow question whether they were denied due process by the Secretary's procedures for evaluating their claims for reimbursement under Medicare Part B. In particular, petitioners argue (Pet. 10) that the claim form prepared by the Medicare program (HCFA-1490) did not track the language of the *Medicare Carriers Manual* provision excluding coverage for routine foot care, Section 4120.1(3)(a), and therefore petitioners were deprived of notice of the specific information they were required to supply in support of their claims.[2] Pet. 11. The judgment of the court of appeals rejecting petitioners' claims is correct. That decision is consistent with decisions of this Court and other courts of appeals. Additionally, the specific question presented here is of limited importance. Accordingly, this Court's review is not warranted.

1. Petitioners' sole contention[3] in this Court (Pet. 7-8) is that one of their due process claims – that the Secretary's disallowance of their Medicare Part B claims is unfair because the Medicare forms on which petitioners submitted their claims failed to inform them of the requirements for filing a valid Medicare claim – is collateral to the carrier's determination on the merits, and therefore is reviewable

[2] As Section 4120.1(3)(a) of the *Medicare Carriers Manual* (see note 1, *supra*, and App., *infra*, 2a) makes clear, at a minimum, a physician must produce evidence of a systemic disease before Medicare will cover routine foot care. Additionally, a podiatrist must name the referring physician who diagnosed the "complicating condition" and the approximate date the beneficiary was last seen by such physician.

[3] Petitioners apparently abandon their additional due process argument, which was the focus of the court of appeals' decision, that the hearing examiner was biased and conducted an unfair review of the evidence. The court of appeals correctly viewed this claim as intertwined with the merits and plainly unreviewable (Pet. App. A4-A6).

in court under *Bowen* v. *Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). The court of appeals did not address this claim as such, perhaps because the focus of petitioners' due process challenge was elsewhere.[4] In any event, petitioners' constitutional claim of inadequate notice is entirely lacking in substance and "obviously without merit." See *Bowen* v. *Michigan Academy*, 476 U.S. at 681 n. 12 (citing *Hagans* v. *Lavine*, 415 U.S. 528, 537 (1974)). The court therefore properly declined to take jurisdiction over their claim.

a. Petitioners' contention that the Secretary failed to provide them with fair notice of the requirements for filing a valid Medicare claim is unsupported by the record in this case. The *Medicare Carriers Manual* (see note 1, *supra*, and App., *infra*, 1a-2a) clearly indicates that routine foot care is not covered under Medicare Part B unless the beneficiary to whom services are provided suffers from a systemic disease of sufficient severity. The regulations also state that the foot care provider must name the referring

[4] At only one point in their brief before the court of appeals did petitioners complain that "[t]here is *no* place or box for the podiatrist to insert the name of the referring [physician]" on the Medicare claim form, and that they were not aware that they were required to supply the name. See Pet. C.A. Br. 25. They went on to state that "the failure of Appellants to follow these phantom regulations [requiring listing of the physician's name and date last seen] is the basis of [the hearing officer's] negative decision." *Ibid.* Based on this statement, the court of appeals may well have understood petitioners to be arguing that the carrier's *application* in this case of the requirement that they list the physicians' names on the original form, despite the absence of a "box" in which to list them, violated their due process rights. As a challenge to the carrier's application of the Secretary's regulations, the claim would appear to be unreviewable under *United States* v. *Erika, Inc.*, 456 U.S. at 203.

physician who diagnosed the "complicating condition" and the approximate date the beneficiary was last seen by the physician. Petitioners nowhere substantiate their assertion that they were "unable to get a copy of the carrier's manual" (Pet. 8). On the contrary, prior to their hearing before the Medicare carrier, petitioners were furnished with a copy of all law applicable to their claims, including Section 4120.1(3)(a) of the *Medicare Carriers Manual.* Petitioners were also provided with an opportunity to submit evidence in support of their claims to the hearing officer. Petitioners in fact availed themselves of this opportunity and introduced additional evidence with respect to a fraction of their claims; as to those claims, the carrier determined the payments were proper. The carrier was correct to apply the *Medicare Carriers Manual* Section 4120.1(3)(a) to deny the claims for which there was inadequate documentation of the treated beneficiaries' medical condition, and the carrier's determination may not be judicially reviewed. *United States* v. *Erika, supra.*

b. Petitioners' complaint (Pet. 10-11) about the absence of a "box" on the Medicare claim form for the listing of a treating physician and date of treatment is beside the point. The record in this case clearly indicates that petitioners' failure to list treating physicians' names on the original claim forms had nothing to do with the carriers' final decision to disallow their Medicare claims. Petitioners were provided ample opportunity to correct any omission of physicians' names from their original claim forms, and the rejection of petitioners' claims was ultimately based on their failure adequately to substantiate the beneficiaries' medical condition, as required by Section 4120.1(3)(a) of the *Medicare Carriers Manual.* See App., *infra,* 4a-6a (August 7 letter). Petitioners do not challenge this requirement, and the record unequivocally shows that they had notice of it.

Because petitioners' initial omission of the names of treating physicians did not affect the ultimate disposition of their claims for reimbursement, petitioners' due process rights could not possibly have been violated by the Secretary's failure to provide a box on the Medicare claim forms for listing the treating physicians' names. In short, the record makes plain that the procedural defect of which petitioners complain had no effect on the disposition of their claims. Therefore, a due process claim based on the inadequacy of the notice provided by the Medicare claim forms is too insubstantial to merit review.

2. Petitioners concede (Pet. 13) that their "claim is probably *sui generis*" and that resolution of the question presented would probably affect only a very small number of cases. Petitioners also note that, in 1986, Congress amended 42 U.S.C. 1395ff to permit judicial review of certain Medicare Part B amount determinations for services furnished after January 1, 1987 (Pet. 13). This amendment deprives this case of ongoing significance and further undermines petitioners' claim that it presents an issue that warrants this Court's consideration.[5]

[5] See Gov't Br. in Opp., *Kuritzky* v. *Blue Shield*, 850 F.2d 126 (2d Cir. 1988), cert. denied, No. 88-685 (Jan. 9, 1989), slip op. 2 n.1; Gov't Br. in Opp., *Association of Seat Lift Manufacturers* v. *Bowen*, 858 F.2d 308 (6th Cir. 1988), cert. denied, No. 88-1044 (Mar. 20, 1989) slip op. 6 n.7.

CONCLUSION

The petition for a writ of certiorari should be denied.
Respectfully submitted.

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JULY 1989

4120. FOOT CARE

4120.1 *Application of Foot Care Exclusions to Physicians' Services.* – The exclusion of foot care is determined by the nature of the service (§ 2323). Thus, reimbursement for an excluded service should be denied whether performed by a podiatrist, osteopath, or a doctor of medicine, and without regard to the difficulty or complexity of the procedure.

When an itemized bill shows both covered services and noncovered services not integrally related to the covered service, the portion of charges attributable to the noncovered services should be denied. (For example, if an itemized bill shows surgery for an ingrown toenail and also removal of calluses not necessary for the performance of toe surgery, any additional charge attributable to removal of the calluses should be denied.)

In reviewing claims involving foot care, the carrier should be alert to the following exceptional situations:

1. Payment may be made for incidental noncovered services performed as a necessary and integral part of, and secondary to, a covered procedure. (For example, if trimming of toenails is required for application of a cast to a fractured foot, the carrier need not allocate and deny a portion of the charge for the trimming of the nails. However, a separately itemized charge for such excluded service should be disallowed. When the primary procedure is covered the administration of anesthesia necessary for the performance of such procedure is also covered.

2. Payment may be made for *initial* diagnostic services performed in connection with a specific symptom or complaint if it seems likely that its treatment would be covered even though the resulting diagnosis may be one requiring only noncovered care.

3. Payment may be made for routine-type foot care such as cutting or removal of corns, warts, calluses, or nails when the patient has a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous (§ 2323C).

a. Claims for such routine services would show in item 7D of the SSA-1490 the complicating systemic disease. Where these services were rendered by a podiatrist this item should also include the name of the M.D. or D.O. who diagnosed the complicating condition. In those cases where active care is required, the approximate date the beneficiary was last seen by such physician must also be indicated.

* * * * *

MEDICARE PART B/GENERAL AMERICAN
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Phone: (314) 843-8700

August 7, 1984

Mr. William R. Blake, Jr.
Associate Regional Administrator
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Department of Health and Human Services
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Federal Office Building
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Kansas City, MO 64106

Dear Mr. Blake:

In response to your letter of July 9, 1984, I wish to reaffirm the decision made in the Medicare Fair Hearing involving Drs. Robert and Richard Bushman. I welcome the opportunity to clarify my position as the hearing office, since it is apparent that the Bushman brothers do not understand the basis of the decision.

Before the hearing itself, I met with Mr. Marglous, the Bushmans' counsel, and provided him with pertinent regulations concerning podiatry services. At that time, we also discussed the sampling procedure used by our program control department. Mr. Marglous was given the opportunity to review the file in its entirety. I explained that at the hearing, my role was to receive any evidence which might have bearing on the matter of the overpayment, that witnesses could be presented, and testimony received. Upon his review of the hearing file, Mr. Marglous requested that the Medicare podiatry consultant be present at the time of the hearing.

On March 19, 1982, the hearing was conducted. The Bushmans' counsel began by questioning Dr. Seiler, the carrier's podiatry consultant. It was apparent from the line of questioning that Mr. Marglous attached a great deal of importance to a document in the hearing file, a letter from Dr. Seiler to the Program Control Department. The letter referred to Dr. Seiler's assessment of a sample of claims from the Bushmans which he had been asked to review. In the course of the hearing, that sample was mistakenly said to be the same sample upon which the overpayment determination was based. Upon questioning, I indicated that I believed the sample to be the same, since no other claims were included in the file. Later events were to reveal, however, that the claims in the hearing file were not those previously reviewed by Dr. Seiler. The sample he actually reviewed was not included in, or part of, the overpayment determinations at issue.

Neither Mr. Marglous nor his clients, the Bushmans, appeared to understand the role of Dr. Seiler in this matter. He was present at the hearing to provide technical and professional assistance to me, the hearing officer, and because his presence was requested by the Bushmans. From the line of questioning, it seemed that Dr. Seiler was seen as the instigator of the Program Integrity case against the Bushmans.

During the hearing, a number of photographic slides were presented and reviewed as additional evidence. In some cases, Dr. Seiler's opinion concerning this evidence influenced my decision to reverse the carrier's determination on particular claims.

The witness Ayoboola Brimmo, M.D. indicated that he had reviewed medical records for beneficiaries treated by the Bushmans. Dr. Brimmo did not personally examine

the patients. I was not able to accept his generalized remarks that elderly patients have compromised vascular status as evidence which met the criteria stated in the Medicare Carrier's Manual.

A letter from Bayard C. Vermilyea, D.O. was presented in evidence. The letter indicated a systemic connotation associated with arteriosclerotic diseases. This letter could not provide a basis for the criteria required by Medicare regulations.

A letter from K. L. Bradshaw, D.P.M. recorded his findings upon examination of 50 nursing home patients treated by the Bushmans. This testimony did not detail any specific findings to support his diagnosis of peripheral vascular disease of the severity addressed by Medicare regulations. He further described peripheral vascular disease as a normal consequence of aging.

A total of 35 nursing home records were presented by the Bushmans as evidence of meeting Medicare's criteria for coverage of routine foot care. This evidence provided me the substantive basis for the majority of my reversals of the carrier's determination.

The Bushmans and their counsel apparently have failed to understand the intention and detail of Medicare's regulations concerning podiatry coverage for routine foot care. The law does not allow the carrier or a hearing officer to accept non-documented generalizations concerning diagnoses.

To conclude, as hearing officer, I found a large portion of the evidence presented to be insufficient under Medicare regulations to warrant coverage of the services performed by the Bushmans.

I would like to add that in the course of the hearing and subsequent proceedings, the issue should have become clear to the Bushmans. That is, the responsibility to document or substantiate services billed to Medicare lies with the provider of those services. Information required on the claim is the responsibility of the provider. The Bushmans were asked for the names of referring physicians, or for diagnoses substantiated by specific symptoms or findings. It should be noted that there was a reduction in the overpayment amount where such evidence was presented. Conversely, where such evidence was not presented, the overpayments were affirmed and remain so to this writing.

Sincerely yours,

/s/ Linda Benso
LINDA BENSO
Medicare Hearing Officer

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